2106.3 Determination if Waiver is Necessary.--Fully evaluate the circumstances under which such waivers are needed or are not needed. If, for example, a State wants to prevent beneficiary overutilization, the exception to freedom of choice under §1915(a) of the Act may be a better alternative than a waiver under §1915(b)(4).

2107. DOCUMENTATION REQUIRED WHEN SUBMITTING REQUESTS FOR WAIVER UNDER SECTION 1915(b)

2107.1 Requirements of Law and Regulations.--The law authorizes the Secretary to waive requirements of §1902 to implement specific programs to the extent he or or she finds it to be cost effective and efficient and not inconsistent with the purposes of title XIX (emphasis supplied). In order for the Secretary to determine that this requirement is met, regulations at 42 CFR 431.55(b) require the State in applying for a waiver to document and maintain data regarding cost effectiveness of the project, effect on recipients regarding access to care and quality of services, and projected impact of the program.

HCFA's approach in granting waivers has been to allow you maximum flexibility in planning your waiver packages. However, you must submit documentation that is sufficient to support a conclusion that all pertinent statutory and regulatory requirements are met. (See §2108.)

HCFA evaluates waiver requests on a project-by-project basis, bearing in mind special circumstances that may apply in each State. Rather than setting rigid standards, HCFA requires you to explain and demonstrate why the proposal will be cost effective, as well as the effect of the project on recipient access to care and quality of services, and the projected impact of the program. Mere assurances will not suffice.

2107.2 Waiver Category.-- Specify in the waiver proposal under which of the four categories (as specified in §2105) you are requesting the waiver and explain why the waiver is being sought under the specified category or categories. A waiver proposal may require more than one statutory authorization. For example, a case management system which shares cost savings from the waiver with the recipients should be requested under §§1915(b)(1) and 1915(b)(3).

2107.3 Statutory Provisions Waived.--The waiver proposal must specify the provisions of §1902 of the Act for which you are seeking waiver and explain why you believe these provisions require waiver.

2107.4 Description of Project.--Waiver projects entail a modification of your existing Medicaid program in order to achieve the objective of one or more of the statutory waiver categories (e.g., a primary care case-management system or restricting recipients to cost effective and efficient providers). In order to fully evaluate a waiver project, fully describe and explain the waiver project and how the State's existing program is to be modified.

The general project description must deal with the following fully and completely:

- Specific categories under §1915(b) that are being requested;
- Statutory provisions waived;
- Purpose of the waiver;
- Services to be provided;
- Types and number of participating providers;
- Qualification requirements for providers and how providers are selected;
- Methods of payment (full capitation, partial capitation), and general description of how payment rates were set and determined;
- Types of reimbursement arrangements or insuring mechanisms being used such as, a risk or nonrisk contract;
- Categories of eligible recipients included in the waiver;
- Nature of participation, e.g., whether voluntary or mandatory;
- Numbers of recipients by category expected to participate, or projections by category of enrollment months;
- Areas of the States in which the program is implemented;
- Project administration costs and activities, including start-up and ongoing costs of administrative requirements and procedures;

- Impact on ongoing Medicaid program administration;

- Means of protecting recipient rights, such as grievance procedures, appeal rights, etc;

- Copies of, or a description of, any contracts for the provision of services under the waiver which must meet the requirements of 42 CFR 434, and an explanation of how the contract relates to the range of services and reimbursement mechanisms proposed in the waiver request (a contract in excess of $100,000, which is also subject to the Federal requirements in §1903(m)(2)(A) of the Act, must be prior approved by the RO. The RO can help you determine if this is the case.);

- Qualification requirements for any contractors;

- Other factors and requirements unique to the State's waiver proposal;

- Documentation on methods to ensure that there will be no restriction of emergency services; and

- Procedures for monitoring costs, utilization, access and quality under the waiver.

2107.5 Documentation Requirements Applicable to Specific Waiver Categories.--Use the general requirements in §2107.4 in describing your waiver proposals, regardless of the specific waiver category being proposed. However, you must provide some additional information , depending on the specific waiver category proposed. Following is a listing of the §1915(b) provisions and the additional information which must be included for each provision:

A. Section 1915(b)(1)-Primary Care Case-Management Systems (PCCM) or Specialty Physician Services Arrangements (SPSA).--Specify who serves as the case manager and provide a complete description of the case manager's qualifications and responsibilities. Since access cannot be restricted to emergency services, indicate how you assure that this requirement is to be met. Additionally, since an individual's freedom of choice of family planning provider and services cannot be restricted, provide a description of how this aspect of freedom of choice is to be guaranteed.

B. Section 1915(b)(2)--Locality as a Central Broker.--Provide identification of which entity will be acting as central broker; complete information on the responsibilities and qualifications of the entity acting as central broker; and complete information about the types and nature of assistance to be offered recipients on how to choose among competing health care plans.

C. Section 1915(b)(3)--Sharing of Cost Savings.--You must provide:

o A full description of the services to be delivered in a more cost effective manner, how they are to be delivered, and how that varies from the services normally delivered under the State plan;

o The amount of savings to be achieved and how they are achieved; and

o The methods by which these savings are to be shared with recipients (e.g. increased services, elimination of copayment or service limitations) and the costs of those services. The calculations should take into account the documentation principles and concepts set forth in §2108.

D. Section 1915(b)(4)--Restriction of Recipients to Specific Providers.--You must provide:

o The standards providers must meet regarding reimbursement, utilization and quality, and whether and how they differ if at all, from those in the State plan;

o Documentation to show how these standards are consistent with access, quality, and efficient and economic provision of services. Standards must be based on written policies, procedures, and criteria that conform to acceptable medical practice and professional standards;

o A description of the type and number of providers to whom recipients are to be restricted, how the providers are selected, and the selection criteria;

o A description of how you assure that providers are selected based solely on demonstrated effectiveness and efficiency in providing services and not on any other standard or criterion which discriminates among classes of providers;

o A description of how you restrict recipients to obtaining services only from qualified providers or practitioners that undertake to provide the covered care or medical services needed;

o A description of how the restrictions are not applied in emergency circumstances; and

o A description of how recipients residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless you arrange for reasonable and adequate recipient transfers.

2107.6 Types of Capitation Contracts.--If projects involve capitation arrangements or contracts, the proposal must indicate which one(s) of the three major types of capitation contracts in 42 CFR Part 434 will be used in the waiver project, and assure HCFA that

these contracts are in conformance with the appropriate regulations. The discussion below of the three types of capitation contracts is meant to highlight their differences and should be used along with the formal definitions in Part 434.

Specify which of the following contract arrangements apply:

A. Health Maintenance Organization(HMO).--An HMO is an entity which has a risk contract to provide comprehensive services directly, in exchange for prepaid capitated payments, either through staff or by arrangements, and if it is not one of the entities listed in §1903(m)(2)(B) of the Act, it must meet the HMO requirements in §1903(m)(2)(A). Services are comprehensive if:

- The organization provides inpatient hospital services and one other service listed in 1905(a)(2),(3),(4),(5) or (7) and the organization is paid on a prepaid capitation or other risk basis; or

- The organization is paid on a prepaid capitation or other risk basis and provides 3 or more of the following services under 1905(a),(2),(3),(4),(5), or (7) of the Act: outpatient hospital and rural health; laboratory and x-ray services; SNF, EPSDT services, and family planning services; physician services; and home health care services. Section 1903(m)(2)(A)(iii) requires that any contract to an HMO in excess of $100,000 have prior approval by the Secretary or his/her designee. This authority has been delegated to Regional Administrators of HCFA.

B. Health Insuring Organization (HIO).--An HIO is an entity which assumes an underwriting risk to pay for medical services provided to recipients in exchange for a premium or subscription charge paid by the State agency. HIOs do not assume medical responsibility for individual services. If the waiver proposes that the contracting entity provide care directly, it is not an HIO. Some HIOs contract with providers and primary care case managers (physician groups) to provide care. Any HIO which became operational on or after January 1, 1986, and which arranges with other providers (through subcontracts or other arrangements) for the delivery of services to Medicaid enrollees on a prepaid capitation risk basis is subject to the requirements for HMOs in §1903(m)of the Act. The distinguishing aspect of an HIO is that it pays bills (rather than provides medical services) and operates similarly to a fiscal intermediary.

C. Prepaid Health Plan (PHP).--The contractor is a PHP if the payment is on a non-risk basis or, if the payment basis is risk and one of the following situations exist:

- The contractor is one of the entities listed in §1903(m)(2)(B) of the Act; or

- The scope of services is not comprehensive. (See subsection A.)

2108. DOCUMENTATION OF COST EFFECTIVENESS, ACCESS TO CARE, QUALITY OF CARE AND PROJECTED IMPACT OF WAIVER ON THE MEDICAID PROGRAM

Document for all waivers the cost effectiveness of the project, the effect on recipients regarding access to care and quality of services, and the projected impact of the project.

For renewal of a waiver, provide data documenting the actual cost experience of the project based on the data obtained for the past project period as well as projections for the future.

The following guidelines are used to document cost effectiveness, access to care and quality of services, and program impact for both a new waiver and renewal of an existing waiver.

A. Cost Effectiveness.--Cost effectiveness has been the documentation requirement that has created the most difficulty for States. In considering new waivers, HCFA must make a determination that the statutory and regulatory requirements regarding cost effectiveness will be met. In waiver renewal requests, HCFA requires data regarding the cost effectiveness of past waiver operations on a year by year basis as well as estimates of how cost effectiveness is to be achieved for each year of the renewal period.

You must demonstrate that the waiver request, regardless of the reimbursement mechanism used, i.e., whether a fee-for-service (FFS) or a capitation basis, is cost effective. At a minimum, use a copy of Exhibit I to demonstrate cost effectiveness.

The test of cost effectiveness for either FFS or capitation is essentially the same, i.e., the costs of the project, for both services and administrative expenses, may not exceed what Medicaid would have paid under the State's plan for comparable services furnished to the same recipients and related administrative costs in the absence of the waiver. The fundamental comparisons which must be fully and completely documented for each project to enable HCFA to make a determination concerning the requirement for cost effectiveness are Medicaid costs with and without the waiver for the same recipient groups and services.

Waiver costs include costs of health care services provided including case management costs, whether in the form of incentive payments to case managers or other costs; any incentive or bonus payments to providers resulting from sharing the savings related to decreased utilization; costs of services offered in addition to those in the State plan, and administrative and systems costs, such as additional staff requirements, staff training, systems development, installation, and operations costs, financial accounting costs.

Costs without a waiver include both service and administrative costs for a comparable population (e.g., a package of benefits that would be available under the State's approved Medicaid plan together with related administrative and systems costs).

1. Costs Without The Waiver.--Develop those costs incurred on behalf of comparable eligible populations, in comparable geographic areas, and with a comparable bundle of program benefits of the types that will be covered under the waiver and as included in the approved Medicaid State plan, but as they would exist without the waiver project. Break down the costs into the elements making up the aggregate totals (e.g., on a per capita basis by Federal eligibility category). Show those costs by each year of the waiver program as projected for new projects, and as experienced for each of the past two years and as projected for each of the next two years for renewal projects. The purpose of developing costs without the waiver is to establish a firm base against which to compare waiver project costs so as to be able to make a determination that the project's cost effectiveness goals are likely to be met. Document these costs as fully as possible as indicated below.

a. General Documentation Requirements. In documenting what costs would be in the absence of the waiver, a State may wish to use Exhibit 2--Example Of A Calculation Of Medicaid Upper Payment Limits For A Risk Capitation Contract And Final Capitation Rate. Although this example, in its title and column headings, indicates it is designed for a capitation contract, it could also be used to demonstrate the projected costs in the absence of the waiver for any waiver model.

To use Exhibit 2 for this purpose, subtitute "waiver project" for the term "contract," and "costs without the waiver" for "upper payment limit." Follow all steps as described in the instructions for Exhibit 2, up to step (v)--calculation of the capitation rate.

The following steps are also provided as an alternative to assist you in documenting this element:

(1) Describe precisely the populations covered in terms of Federal eligibility category, institutionalized or non-institutionalized, and other important demographic characteristics (e.g., age, sex). Calculate estimated levels of Medicaid eligibility for each year of the project based on past experience or trends or factors that are specifically identified;

(2) Describe precisely the specific types of services covered in the calculations;

(3) Provide calculations of the utilization rates for specified services for the defined populations in the absence of a waiver (e.g., inpatient hospital, physician visit, and emergency room use);

(4) Display costs separately for each major geographic area or political sub-division covered under the waiver (e.g., county, Standard Metroplitan Statistical Area (SMSA), etc.). Where a waiver is to be phased-in, provide costs for each area covered under the waiver.

NOTE: Use only those costs that are reimbursable under the State-Federal Medicaid program. For example, the institutional costs of persons housed in institutions for mental illness who are aged 22 through 64 are not chargeable to the Medicaid program and therefore these institutional costs of care should not be included. Similarly, costs of State general medical assistance programs and costs of Medicaid services that are not proposed to be covered under the waiver, such as inpatient hospital costs for a waiver designed to cover only physician visits and outpatient services, are not to be included;

(5) Indicate costs for each service by each population (described in subsection (1) and describe how these costs were developed;

(6) Document, by showing historical year to year changes, or using some other reasonable and justified methodology, the basis for any health cost inflation factors that are used. These factors must to the maximum extent possible, be separated by major type of health service;

(7) Describe and calculate the effect of changes in State law and policy that are likely to affect the costs of health services provided to Medicaid eligible populations to produce an appropriately adjusted base cost. These could include changes in State policy such as the introduction of new prior authorization procedures, institution of new reimbursement levels or methodologies, known changes in benefits or similar factors, etc;

(8) Fully document adjustments or offsets to recorded costs:

(a) Document how third party liability recoveries or discounts were reflectd; and

(b) Document how coinsurance, copayments, and other related payments were reflected;

(9) Fully document how non-Medicaid eligible recipients and services been excluded; and

(10) Fully document all administrative cost calculations, such as claims processing, utilization review, quality of care monitoring, that are borne under the regular Medicaid program which relate to the populations and the cost of services provided under the waiver. Use of average per capita State administrative costs are acceptable.

b. Upper Payment Limit for Capitation Contracts.--For proposals involving capitation arrangements, most States choose to demonstrate compliance with the upper payment limit requirement and calculate costs without the waiver, using the same set of computations. The elements or factors needed to be taken into account, required for calculating this limit, are similar to those in the general documentation requirements above. Specific requirements must be met for capitation contracts, including the upper payment limit for prepaid capitation plan found at 42 CFR 447.361 and 447.362. In general, the upper limit of payment for capitation contracts on a risk basis (e.g., HMO, HIO, or PHP) is the State agency's estimated cost of providing the

scope of services covered by the capitation payment if these services were provided on a FFS basis to a non-enrolled recipient population which is actuarially equivalent to the contractor's enrolled recipients. The State agency's total payments to the HMO may not exceed the agency's payment on a FFS basis for these same types of services, plus the agency's average per capita administrative costs related to these services. (For the non-risk capitation contract limit, see 42 CFR 447.362.) An example of an upper payment limit calculation is provided in Exhibit 2. Documentation for the upper limit must be calculated on a per eligible per month basis. As in the general documentation requirements, these calculations must be for comparable populations, services and geographic areas. All adjustments such as those for inflation and policy/program impact must be documented. These calculations must clearly demonstrate that when compared, (1) payments to the contractor do not exceed the upper limit rates and (2) costs under the waiver do not exceed costs without the waiver.

(1) Waiver Project Entirely on a Capitated Basis.-- If a waiver project is entirely on a capitation basis, then payment limit (or the sum of entirely on a capitation basis, then the upper payment limit (or the sum of all the limitsd if there is more than one capitation contract) may serve as the upper payment limit(s) for these contracts and, in addition, can be used to establish the State's costs without a waiver, as described above.

(2) Waiver Project Not Entirely on a Capitated Basis.-- If you make payments both on a capitation basis and on another basis (e.g., FFS, physician bonuses if they achieve reduced inpatient utilization), separately calculate your upper payment limit(s) for your capitation payments from other payments. Both together would comprise costs without a waiver, as described in the opening paragraph of this subsection b. Both calculations must follow a similar process and, as appropriate, contain common elements but the final figures should be different because of key differences in their scope (e.g., services, recipients etc.).

2. Waiver Project Costs.--Estimated waiver project costs are the second area that must be fully documented in order to allow a determination on the cost effectiveness of a project. Waiver project costs include program benefits, administrative costs, public information, claims processing, auditing fees, and special features such as case-management fees, marketing incentives, and bonuses for sharing the savings due to decreased utilization of services with providers. Program benefit costs must be separated by payment basis and type (e.g., FFS, capitation, bonuses, etc.). For capitated providers or contractors, state the capitation rates and document the methods by which these rates are established and estimated. (See 42 CFR 434.23 and 434.61.) If you make payments on a capitation basis and another basis (e.g., FFS, bonus payments) estimate all costs and both sets of requirements below must be met.

a. Payments to Fee for Service (FFS) Providers for Program Benefits.--The requirements for FFS providers are specified in 42 CFR Part 447. Indicate in the proposal that these requirements must be met, unless waivers are requested of specific regulations that implement §1902 (a)(30) of the Act. In order to demonstrate the costs under the waiver, the general documentation factors described in subsection 1.2., General Documentation Requirements must be used again.

b. Specific Capitation Requirements.-- Payments by State agencies on a capitation basis are made under the authority of 42 CFR Part 434. To the extent these regulations are based on §1902 (a)(30) of the Act, they can be waived for a particular contractor, so long as the project's total costs are still cost effective. The primary payment requirements for each capitation contract pertain to the relationship of the capitation payments to the upper limits of payment and the actuarial soundness of the capitation rates. These requirements are further elaborated upon below.

(1) Capitation Rates

(a) Upper Payment Limit.--Payments under capitation contracts may not exceed the upper payment limits for prepaid capitation contracts found at 42 CFR 447.361 and 447.362. These limits are discussed in subsection A.1.b. of §2108.

(b) Actuarial Basis.--The actuarial basis for the capitation rates must be specified in the contract, and in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the upper payment limit (e.g., see Exhibit 2, last step); a budget-based rate (e.g., the HMO's cost); and the contractor's community rate (i.e., if it is a Federally qualified HMO) with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

You may use other methods as well. If there are adjustments for stop-loss and reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the upper payment limit, unless a waiver is granted of §1902 (a)(30).

(c) Actuarial Soundness.-- Although the law and regulations do not specifically require that an actuary be used for demonstrating the actuarial soundness of payments the State makes, this demonstration can be made most easily if the proposal indicates that the payment basis was calculated by an actuary or if an actuary certifies the soundness of the basis for determining the payments. If you do not use an actuary in either of these ways, describe, with appropriate documentation, why you believe State payments will be on an actuarially sound basis.

(2) Other Capitation Requirements.--In support of the above requirements, indicate in the proposal that, in determining the upper payment limit and capitation rates, there are payment mechanism controls in place, to insure that all payments to the contractor and your costs are taken into account so that a valid comparison can be made between the upper payment limit and the State's costs under the contract. Examples of payment mechanism controls include the following:

(a) Identification of areas where you and the contractor share financial responsibility;

(b) Systems to avoid duplicate payments (e.g. FFS providers billing for services covered by the capitation payments);

(c) Reporting basis for costs reported for non-capitation payments you make in addition to your capitation payments (e.g. State reinsurance for costs over a specified amount); and

(d) Identification and allocation of State payments under its FFS payment system for emergency services furnished to the contractor's enrollees.

B. Recipient Access to Services and Quality of Care.--A waiver program under §1915(b) may not substantially impair a recipient's access to services of adequate quality. Your request for waiver must provide sufficient documentation to assure an adequate amount of services during reasonable time periods and within reasonable geographic distance of the residence of participating Medicaid recipients. It must also show that access to emergency services is assured.

If you request waiver under §1915(b) you must include the following information in order to document the proposal's impact on recipients' access to services and quality of care:

o The number of providers who are expected to participate in the proposed waiver program, by type of service offered and by location; and how the rate of provider participation under the proposed waiver compares to the current rate of participation;

o The average distance and travel time for recipients to obtain medically necessary services and how this compares with times and distances without the waiver;

o How enrollments and disenrollments (if applicable) are to be handled under the proposed waiver;

o A description of the grievance system for participants in the waiver program and how the grievance system works; (Note that a waiver may not preclude a recipient's right to a fair hearing under the rules that apply to non-waiver recipients);

o A comparison of the services covered under the waiver to those covered under the ongoing Medicaid system;

o An explanation of how participants obtain medically necessary services not covered by the waiver program;

o A description of the marketing plans, if any, for the waiver program;

o A description of the quality assurance mechanisms which ascertain that quality of services is maintained under the waiver; and

o Documentation that recipients' access to emergency services is not restricted under the waiver.

C. Program Impact.--The Medicaid statute requires that the impact of waivers be consistent with the purpose of the Medicaid program. This purpose, as stated in §1901 of the Act, is to enable the State to furnish medical assistance on behalf of families with dependent children, and aged, blind and disabled individuals lacking the income and resources to meet the costs of necessary medical services, and to help such families and individuals attain the capability for independence or self-care. In order to document the program impact of a proposed waiver, include the following information:

o A statement of how the requested waiver is consistent with the purpose of the Medicaid program, as described above; and

o A description of the impact on recipients in the State if the waiver is approved.

2109. REQUESTS FOR MODIFICATION OF AN APPROVED WAIVER PROGRAM

You may wish to modify some aspect of a previously approved waiver program, as described in subsections A-C. Submit your request for modification to the HCFA RO, which in turn forwards your request to central office along with its recommendation.

A. Delays in Implementation.--In the event that a State loses a significant amount of time between approval of its waiver authority and the actual date of implementation, it may request a change in the waiver's effective date to allow the waiver a full two-year term. Your request for delay in a waiver's effective date must include the reasons for the delay, documentation of any impact of the delay on the program's cost effectiveness and other requirements that must be met for approval, and the preferred date of implementation. Requests for delays in implementation can only be approved if no expenditures have been made for program benefits by the time of the newly proposed effective date.

B. Other Modifications.--HCFA considers other requests for modification of approved waiver authorities, (e.g. changes in the groups or areas of a State covered under a waiver program). Requests for modification of a waiver must include a detailed description of the intended change, and your rationale for requesting the modification. Documentation of the impact of the proposed modification on the program's cost effectiveness and recipients' access to services of adequate quality and other criteria must be provided in accordance with the guidelines in §2108 along with any other documentation that may be required under §2107, such as addition of a new waiver category, and the addition of other provisions of §1902 for which waiver is required. In essence, a modification must be accompanied by a full justification and cost data similar to that required for a new or renewal waiver proposal.

C. Processing Requests for Modification.--HCFA will process requests for modification of existing waiver authorities in accordance with the provisions for processing initial requests for waiver in §2106.

2110 WAIVER RENEWALS

You may request and receive approval for continuation of a waiver project. Each renewal may be for a 2-year period.

A. Submitting the Renewal Request.--A request for a renewal of a waiver program must be submitted at least 90 days, but no earlier than 120 days, before the date the existing waiver expires, to ensure an uninterrupted waiver program. Such requests, with all appropriate documentation as required by §§2107 and 2108, must be submitted to the RO.

B. Processing of Waiver Renewal Request.--A request for a renewal of a waiver program (regardless of whether changes in the program are proposed) is processed under §1915(h) of the Act. This section requires that the Secretary either approve or disapprove, in writing, the request within 90 days of receipt of the waiver renewal request, or inform the State agency that additional information is needed in order to make a final determination of the waiver request. In this case, a new 90-day period of consideration begins once the response to the request for additional information is received. (See subsection D for instances in which additional information is requested prior to a final determination being made.)

C. Evaluating the Waiver Renewal Request.--In determining whether to grant a renewal, as well as for purposes of evaluating the waiver project, HCFA must determine whether the project has met the requirements established by statute, and has indeed been cost-effective and efficient.

Specific information must be presented to HCFA documenting for each year of the waiver the actual cost effectiveness of the project, the actual effect on recipients regarding access to care and quality of services, and the actual impact of the program. The documentation must show the extent to which these requirements, as defined in §§2107 and 2108, were met during the approved project period and provide a basis for determining that statutory requirements will be met during the requested renewal period. In addition, if you request a renewal of the waiver, you must provide a rationale for renewing the project as well as a justification and data to show how requirements will be met for each year of the renewal

Any proposed modification requested as part of a renewal must be documented as provided in §2109.

D. Request for Clarification and Additional Documentation.--In instances where your submittal of specific documentation does not support a finding that the waiver has satisfied the conditions for which it was approved or clarification is needed, you are asked to provide additional information. Requests for additional information in this instance stop the 90-day period in which the Secretary must approve or disapprove the continuation

request. A new 90-day period begins upon HCFA's receipt of the requested additional documentation. (See §1915(h) of the Act.) Work closely with RO staff in preparing the necessary documentation in order to ensure that all waiver requirements are fully met.

If HCFA is ultimately unable to make a finding, based on the information you provided that the waiver project has met the statutory and regulatory requirements and has been cost-effective and efficient, the request for a 2-year continuation is disapproved. HCFA considers what steps are necessary to assure continuity of services to recipients under these circumstances.

Where HCFA needs additional information prior to deciding whether to approve or disapprove your proposal, your waiver as initially approved may be extended for 90 days if the waiver is about to expire. Thus, you have the opportunity to respond to HCFA's request for additional information without the continuity of the waiver being jeopardized. Once you respond to the request for additional information, HCFA either approves or disapproves the waiver.

Where you do not respond to HCFA's request for additional information by the end of the 90-day extension, the waiver automatically terminates.

2111. MONITORING, EVALUATION, AND TERMINATION OF WAIVERS

42 CFR 431.55(b)(4) provides that HCFA monitors the implementation of waivers granted to assure that requirements for granting such waivers are being met. Additionally, where monitoring produces evidence that is not in compliance with the requirements for a waiver under this section, you are given notice and an opportunity for a hearing. If, after the hearing, HCFA finds you out of compliance with the requirements of the waiver, the waiver is terminated, and you are given a specified date by which you must demonstrate that you meet the applicable requirements which apply in the absence of the waiver.

A. Monitoring.--The RO has the primary responsibility for monitoring your implementation of the Medicaid program and approved waivers. Such monitoring is conducted by RO staff with assistance by appropriate staff from central office.

B. Independent Assessment.--As a condition of approval of a waiver, HCFA requires that an independent assessment must be conducted. This independent assessment is submitted to HCFA by the date specified in HCFA's approval letter, usually 6 months prior to the expiration date of the approved waiver period. The assessment must be conducted by a contractor or agency that is independent of the Medicaid agency.

"Independent of the State Medicaid Agency" means either:

- An outside contractor, university, or other entity outside of the State government; or

o Another entity within the State government that is not responsible to the Medicaid State agency or the agency responsible for administering the waiver program (including another administrative part of an umbrella agency in the State of which the Medicaid agency or the agency administering the waiver is also a part).

For example, if a State's audit or assessment office does not report to the State Medicaid Agency or any other agency with responsibility for the waiver, it is able to perform an independent assessment even if that audit or assessment office reports to the umbrella agency, which includes the State Medicaid Agency.

The independent assessment must focus on an evaluation of, and make findings related to, the statutory and regulatory requirements for approval in §§2105 and 2107, and any other specific requirements made by HCFA in its approval of the waiver request.

2112 FREEDOM OF CHOICE - FAMILY PLANNING SERVICES UNDER §1915(b)

Under a §1915(b) waiver, the right of individuals to choose a provider with respect to family planning services may not be restricted. This requirement applies to freedom of choice waivers as follows:

o If a recipient chooses to receive a package of medical services offered by a particular plan, he has exercised his right of freedom of choice for all items of medical care included under the package, except for family planning services and supplies furnished to individuals of child bearing age who are eligible under the State plan. In the case of family planning services and supplies, the enrollment of a recipient in a primary care case management system (as described in §2107A), an HMO, or a similar entity does not restrict the choice of provider from whom the recipient may receive family planning services and supplies. Assure that the terms of membership are fully and clearly explained, so recipients are aware of the limitations on their right of free choice of providers for services available under the plan.

o Recipients must be provided sufficient information to allow them to make an informed choice including an understanding of whether family planning services is available to them and the type available.

o When a mandatory assignment of a recipient to a primary care health provider occurs, there is no exercise of the freedom of choice of a family planning provider. The recipient may select a family planning services provider of his/her choice.

o For purposes of this section, a primary care health provider includes HMOs, Health Insurance Organizations (HIOs), a specialty physician as well as a primary care physician.

Recipients may request a hearing before the State agency, as required under §1902(a)(3) of the Act, if they believe their free choice of provider has been denied or impaired without due process. (See Subpart E, 42 CFR 431.200-431.246.) These regulations apply if recipient is dissatisfied with family planning services as with any other service.

2113 TRANSPORTATION TO PROVIDERS OF SERVICES

42 CFR 431.53 requires States to assure necessary transportation to recipients to and from providers. A description of the method of assurance to be used must be included in your title XIX State plan. Transportation must be covered either under your administrative requirements, or as an optional State plan item of medical assistance, or may be included under both categories.

If it is apparent to you that the number of choices of any particular type of provider is significantly limited, you may authorize transportation to allow a reasonable selection of appropriate providers. For example, if there is only one dentist in a community and he is unable to meet the dental care needs of the recipients in that area without working overtime or requiring delayed services, you may authorize transportation to services not otherwise available, to alleviate the situation. Freedom of choice does not require you to provide transportation at unusual or exceptional cost to meet a recipient's personal choice of provider.

Since the free choice provision applies only to providers of medical services, transportation services for which you claim reimbursement as an administrative expense are not subject to the freedom of choice provision. For such transportation, you may designate allowable modes of transportation, or arrange for transportation on a pre-paid or contract basis with transit companies. Consider transportation for which you claim reimbursement as a medical expense (e.g., ambulance service) within the free choice rights of the recipient. You may enter into contractual arrangements for medical transportation and inform recipients of the availability of this service. Also, you may establish allowable payments for private medical transportation not to exceed the costs which would have been incurred under the contract, for comparable services. However, you must not limit medical transportation to its contractual arrangements.

2114 CASE MANAGEMENT FOR WHICH NO WAIVER IS REQUIRED

Case management services may be offered as medical assistance under the State plan provided that the recipient is not locked into a designated provider of medical assistance. Thus, the freedom of choice requirements must be met. This benefit is available without regard, to the requirement that services be provided on a statewide basis (see §1902(a)(1) of the Act), and the requirements relating to the amount, duration and scope of medical assistance (see §1902(a)(10)(B) of the Act). Case management services for purposes of this subsection means services which assist eligible individuals in gaining access to needed medical, social, education, and other services.

A waiver is needed to restrict the recipient's freedom of choice in providing case management services, as provided for in §2105A.

SUMMARY OF WAIVER'S COST EFFECTIVENESS[1]

Period: _____ to _____

I. State Costs Without the Waiver(s)

Type of Cost (s)		Supporting Documentation Location
A. Administrative.	_____	_____
B. Payments to Providers		
1. FFS basis. .	_____	_____
2. Capitation basis. . .	_____	_____
3. Subtotal.	_____	
TOTAL COSTS WITHOUT WAIVER..	_____	

II. State Costs With the Waiver

Type of Cost (s)		Supporting Documentation Location
A. Administrative.	_____	_____
B. Payments to Capitated Providers		
1. Capitation Payments	_____	_____
2. Bonus Payments	_____	_____
3. Other Payments	_____	_____
Subtotal.	_____	
C. Payments to fee-for-service providers.	_____	
TOTAL COSTS WITH WAIVER.	_____	

[1]Show only costs of furnishing services to recipients for which Federal financial participation is available.

CALCULATION OF MEDICAID UPPER PAYMENT LIMITS FOR A RISK CAPITATION CONTRACT AND FINAL CAPITATION RATE

STEP 1: For the geographic area covered by the contract, show the fee-for-service (FFS) base year costs of the target enrollment population by eligibility category, age, and sex.

	Total Eligible Months (a)	Eligibles* (b)
AFDC	540,000	49,090

* Total eligible recipients covered by Federal financial participation who are eligible for the capitation program.

STEP 2: Show total costs of services (Col.g) by major service category.

	Service X** (c)	Service Y** (d)	Service Z** (e)	Total Costs*** (f)=(c+d+e)
AFDC	$22,000,000	$10,000,000	$6,000,000	$38,000,000

** Generic groupings of services such as: inpatient hospital, outpatient hospital, physician, lab and x-ray, etc.

*** Cost for all State plan services to be covered under the capitation contract, based on actual incurred costs for the base year.

STEP 3: Adjust, as necessary, total FFS costs of EACH service category from the base year to the year when contract takes effect. Examples include changes in utilization, pricing, and coverage, such as policy changes which have been adopted since the base year.

	Base Year Total Costs of Service X, Y,Z, etc. (g)	Utilization Factor* (h)	Pricing Factors** (i)	TPL Factors*** (j)	Other Policy Factors**** Affecting Services X,Y,Z (k)	Capitation Year Total Projected costs of Services X,Y,Z (l)=g(h+i+j+k)
AFDC	**X** = $22,000,000	-12.55%	+2.87%	-2.25%	+3.01%	$ 20,037,600
	Y = $10,000,000	+9.65%	+1.13%	-	-2.64%	$ 10,814,000
	Z = $ 6,000,000	+1.70%	+2.00%	-	-1.92%	$ 6,106,800
						$ 36,958,400

* Adjusts for utilization changes since base year (actual changes in the volume or intensity of services in FFS).

** Adjusts for changes in FFS prices (e.g., inflation in the Medicaid program or changes in the fee schedules used by State) since base year.

*** TPL Adjustment - applies only if (a) State has not excluded TPL recoveries from its FFS costs in the base year and/or (b) provider collects and keeps TPL rather than the State and is deducted.

**** Adjusts for fiscal impact of changes in coverage, etc.

NOTE: Adjustments should be made to relevant service categories, as appropriate.

STEP 4: Apply adjustments and projected eligible months to determine upper payment limit.

	Total Costs of Services X,Y,Z, etc. (m)	State Agency Administrative Cost (Apportioned)* (n)	Total Projected Cost of FFS Program (o)=(m+n)	Total Projected Eligible Months (p)	Per Capita** Upper Payment Limits (q)=(o/(p)
		w/o demographic breakdown		(Column C adjusted to current demo-graphic eligibility distribution in Medicaid)	
AFDC X = $20,037,600 **Y** = $10,814,000 **Z** = $ 6,106,800					
	$36,958,400	$143,000 ($.265 per capita administrative cost)	37,101,400	540,000	$68.71

* Administrative Costs - is the average cost of providing administrative service in the State on a fee-for-service basis to the target population. The State should apportion the administrative cost in proportion to the number of each category of eligible recipient and based on the relevant administrative services provided in the State (claims processing, utilization controls, etc.)

** Upper limit rate. All payments to the contractor are subject to this upper payment limit. Depending on project design, this includes capitation payments, bonus payments, risk sharing or stop loss payments (i.e., any payments to the contractor).

STEP 5: Make system-wide adjustments between FFS and Capitation (differences between the liabilities, financing, and administration of the capitation system versus the fee-for-service financing system) to derive the final capitation rate.

	Capitation Year Total Cost of FFS Program (unadjusted) (r)	Reinsurance Adjustment (optional)* (s)	Adjustment for Retroactive Eligibility (optional)** (t)	Other Adjustment*** (u)	Final Capitation Rate (v)=u (r-s+t)
AFDC	Column r Total				
	$68.71	-$0.98	-$1.82	.95%	$62.62

---

* Reinsurance Adjustment - applies if the State elects to provide stop-loss or reinsurance coverage under the capitation contract. The State must document the probability of incurring costs in excess of the stop-loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs.

** Retroactive Eligibility Adjustment - reflects differences in eligibility policies between FFS and capitation. HMOs that service Medicaid recipients with retroactive eligibility are not liable for expenses prior to enrollment.

*** In this example the capitation rate is set at 95 percent of FFS.

*** Use this adjustment as appropriate.

Instructions to Example of the Medicaid Upper Payment Limit and Capitation Rate Calculation

The worksheet is an example of a calculation of the Medicaid upper payment limit for a risk capitation contract and the final capitation rate. To better understand the worksheet, we have developed a set of figures and narrative explanations, column by column. The reader should bear in mind that the various adjustments used in the worksheet are examples and should not be considered all inclusive. Additionally, the adjustments have been simplified for illustration purposes.

Assumptions

1. 49,090 AFDC eligibles covered by contract.
2. Average number of eligible months in base year period is 11.
3. Service "X" represents inpatient hospital costs.
4. Service "Y" represents outpatient costs.
5. Service "Z" represents all other medical service costs.
6. Capitation rate set at 95 percent of FFS upper limit.

Column Explanations

(a) Actual figures, derived from the State's management information system (MIS) for the previous fiscal year, indicated a total of 540,000 AFDC eligible months.

(b) The MIS indicated that the total number of AFDC eligibles in the previous year was 49,090.

(c); (d); (e); and (f)

The MIS indicated that the following costs were incurred by the State during the base year period for providing all medical service categories: inpatient hospital -$22,000,000; outpatient hospital - $10,000,000, and all other - $6,000,000. Therefore, a total cost of $38,000,000 ($22,000,000 + $10,000,000 + $6,000,000) was incurred by the State for providing all medical service categories to the total 540,000 person eligible months in the FFS program.

(g) $22,000,000; $10,000,000, and $6,000,000, from Columns (c), (d), and (e).

(h) New policies adopted by the State after the base year affected utlization rates as follows: inpatient rates decreased 12.55 percent resulting from implementation of a DRG-based prospective payment system and lower average length of stays; outpatient utilization increased 9.65 percent due to an expanded ambulatory surgery program; and all other services utilization increased 1.70 percent due to increased family planning services.

(i) FFS price adjustments implemented by the State since the base year period resulted in the following: (assume inpatients reimbursed on DRG basis; outpatient services reimbursed on a cost basis and all other services are paid according to fixed fee schedules) a 2.87 percent increase in inpatient hospital services due to an increase in room and board rates; a 1.13 percent increase in outpatient hospital services based on the annual CPI adjusted inflation factor; and a 2.00 percent increase in all other services due to fee schedule increases for primary care services.

(j) During the base year period, the State did not exclude third party liability (TPL) recoveries for FFS inpatient hospital service costs. Since the total amount of TPL recoveries was $495,000, this represented 2.25 percent ($495,000 divided by $22,000,000) of total inpatient costs. Therefore, 2.25 percent is posted under Column j for Service X (inpatient) and is a negative adjustment.

(k) Other policy factors which affected the base year period costs were as follows: a 3.01 percent increase in inpatient services caused by the implementation of a pre-admission review program for non-emergency inpatient admissions; a 2.64 percent decrease in outpatient services due to the elimination of physical therapy coverage; and a 1.92 percent decrease in all other services due to State elimination of AFDC subsidy for public transportation fares.

(l) Total projected costs are determined by multiplying the base year period costs (Column g) times the sum of Column h + Column i + Column k. In our illustration this is computed as follows:

Service X = $20,037,600 ($22,000,000 X 91.08%)

Service Y = $10,814,000 ($10,000,000 X 1.0814%)

Service Z = $6,106,800 ($6,000,000 X 1.0178%)

(m) Same as column 1.

(n) Administrative costs include claims processing, contract administration,, quality assurance audits, broker fees, marketing, management information system, and legal fees. In our illustration assume the FFS program's total administrative cost was $143,000. The average per capita administrative cost is $.265, derived by dividing total projected eligible months or 540,000 (Column a) into $143,000.

(o) The total projected cost of the FFS program is $37,101,400, derived by adding the total costs of services or $36,958,400 (Column m) to total administrative costs or $143,000 (Column n).

(p) Since the State pays one payment rate for the AFDC program, no demographic eligibility adjustments are made. Therefore, the number of total projected eligible months is 540,000 (Column a). A more actuarially sound approach is to designate specific rates by age and sex.

(q) The per capita upper payment limit is $68.71 derived by dividing total projected eligible months or 540,000 (Column p) into total projected FFS program costs or $37,101,400 (Column o). Note that Columns (a) through (q) dealt with calculating the upper payment limit. The remaining Columns (r) through (u) are the calculations from which the final capitation rate is derived.

(r) Column q or $68.71.

(s) Assume the State elects to provide stop-loss coverage for catastrophic expenses under the capitation contract. The stop-loss calculations must be actuarially sound. In our illustration assume that there is a limit of $10,000 per year per enrollee. The State is the reinsurer in this case and establishes a risk pool to cover stop-loss payments. The estimated per capita costs (over $10,000) are subtracted from the FFS maximum. For AFDC this figure was $.098 per eligible- month and is deducted from the FFS per capita cost estimate of $68.71.

(t) Medical expenses for retroactive eligibility periods are estimated to cost the Medicaid program (under FFS), $1.82 per capita per month. Since the contractor is <u>not</u> liable for expenses incurred during these periods, an adjustment is made by subtracting the $1.82 from the FFS upper payment limit.

(u) The State sets its capitation rate at 95 percent of the upper payment limit adjusted by columns (s) and (t) above.

(v) The final capitation rate is derived by multiplying Column (u) or 95% times the sum of Column (r) + Column (s) + Column (t). In our example the calculation is 95% X $65.91 which equals $62.62. The $62.62 represents the payment rate which will actually be made to the contractor. Note that this is below the FFS $68.71 determined upper payment limit rate.

2200. REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

A. General Provision.--An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State). It relates to the provision of medical care when the individual is incapacitated. You, an association, or other private nonprofit entity must develop a written description of the law of the State concerning advance directives. Include this description in your State plan and furnish the information to providers, HMOs, and HIOs participating in your Medicaid program for distribution to patients. Indicate in your plan whether State law allows a health care provider to object to the implementation of an advance directive on the basis of conscience.

B. Provider Participation.--Your State plan must require that each provider receiving funds under the plan maintain written policies, procedures, and materials concerning advance directives to ensure compliance with the law. An agreement between the Medicaid agency and the provider is one acceptable way for the State plan to illustrate that providers are disseminating the required information. Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, HMOs and HIOs must:

o Give written information to all adults (as defined by State law) receiving medical care concerning their rights under State law to:

- make decisions concerning their medical care,
- accept or refuse medical or surgical treatment, and
- formulate advance directives, e.g., living wills or durable power of attorney for health care;

o Provide written information to all adults on their policies concerning implementation of these rights;

o Document in the individual's medical record whether he/she has executed an advance directive.

o Not condition providing care or otherwise discriminate against an individual based on whether he/she has executed an advance directive;

NOTE: The statute is explicit that this provision is not meant to be construed as requiring care that may conflict with an advance directive. For example, the patient is entitled to the necessary care ordered by a physician which a provider under normal procedures must furnish and cannot delay care while waiting for a directive. However, once it is documented that an advance directive has been executed, then the directive takes precedence.

o Ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) concerning advance directives; and

o Provide for educating staff and the community on advance directives. You may specify in the plan what you will require providers to do to educate staff and the community or that you will let providers devise their own campaigns. As long as providers conduct educational campaigns, this requirement is met. This can be accomplished by newsletters, articles in the local newspapers, local news reports, or commercials.

C. When Providers Give Information Concerning Advance Directives to Adult Individuals.--Your State plan must specify when information concerning advance directives is given to each adult patient from each type of provider as follows:

o A hospital must give information at the time of the individual's admission as an inpatient.

o A nursing facility must give information at the time of the individual's admission as a resident.

o A provider of home health care or personal care services must give information to the individual in advance of the individual's coming under the care of the provider.

o A hospice program must give information at the time of initial receipt of hospice care by the individual.

o An HMO/HIO must give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or reenrolls the individual. If an HMO has more than one medical record for its enrollees, it must document all medical records.

D. Information Concerning Advance Directives at the Time an Incapacitated Individual Is Admitted.--An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he/she has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with State law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once he/she is no longer incapacited.

E. Previously Executed Advance Directives.--When the patient or a relative, surrogate or other concerned or related individual presents the facility with a copy of the individual's advance directive, the facility must comply with the advance directive including recognition of the power of attorney, to the extent allowed under State law. Absent contrary State law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether he/she has executed an advance directive, the facility must note that the individual was not able to receive information and was unable to communicate whether an advance directive existed.

F. Availability of Federal Financial Participation (FFP).--FFP at the 50 percent matching rate is available for State administrative costs of implementing the requirements of this section, specifically the development, education, and distribution of information to providers and recipients.

2350. LEGISLATIVE BACKGROUND

Section 2113 of the Omnibus Budget Reconciliation Act of 1981 provides for the optional use of PSROs under State Medicaid plans. Section 1164 of the Social Security Act which had imposed the statutory PSRO requirements upon the operations of State Medicaid programs, has been repealed. Section 1155 (a) (1) of the Social Security Act was amended to require a PSRO as part of its agreement with HCFA to enter into a contract with a State Medicaid agency at the request of the State. Section 1902 (d) was amended to permit the State agency to satisfy the required medical review or utilization review functions of Title XIX through its contract with a PSRO for review of these functions. Section 1903 (a) (3) was also amended and provides for Federal financial participation (FFP) of 75 percent for such State-PSRO contracts. Any agreement between HCFA and a PSRO which is entered into on or after October 1, 1981 is governed by the above amendments. A PSRO is expected to perform review of those health care services provided under the State plan under terms and conditions similar to those contained in the agreement between HCFA and the PSRO for the review of Medicare services. A PSRO with a current HCFA agreement which was entered into before October 1, 1981 will continue to have responsibility for the review of health care services provided to recipients of Medicaid until the next renewal of that agreement or in accordance with instructions in the current agreements.

Interim final regulations implementing section 2113 were published in the Federal Register on October 1, 1981. In addition to deleting references to title XIX from those Federal regulations mandating PSRO review of Medicaid services, several specific changes were made to accommodate PSRO/State agency review contracts. The intent of these regulations is to maximize flexibility within the context of the new statutory requirements, basic State plan administration rules, and contracting procedures.

2351. STATE-PSRO CONTRACTING PROCESS

A State may enter a contract with a PSRO to perform review only in its designated area, in another PSRO area, (including an area where a PSRO has been defunded for Medicare review), or with a PSRO in another State. A State-PSRO contract may include a provision for a sub-contract with another Federally funded PSRO, or with a hospital, or with a SNF or an ICF, (if either is a distinct part of a hospital), for part of the review activities in the State. All of these situations would allow for 75 percent Federal Financial Participation (FFP) for expenditures to perform review under the contract.

2351.1 OMB Requirement.--OMB Circular A-102 sets forth the Federal guidelines for procurements by grantees such as State Medicaid agencies. In the case where a State contracts with a local PSRO to perform review only in its designated area, the Circular would automatically allow a sole source procurement process, since only the local PSRO could enable the State to qualify for 75 percent FFP in that instance. In any other case, whether resulting in a 75 percent FFP or not, the OMB Circular A-102 requirements for establishing the method of procurement would have to be applied on a case-by-case basis.

235l.2 Contract Negotiations.--Although the PSRO is required to participate in the contract if the State so elects, the State is expected to provide the PSRO with adequate lead time to negotiate mutually acceptable terms. Generally the minimum lead time is recommended as 90 days from the date on which the State formally indicates to the PSRO its interest in contracting. Since a State-PSRO contract is intended to satisfy Medicaid review requirements, it is essential that the State formally notify the PSRO by letter of its interest in a contract, with an informational copy to the regional office. When negotiations begin, the HCFA regional office may be requested by either party to provide technical assistance in order to finalize the arrangements. The plan amendment to enable expenditures under the contract to be matched at 75 percent FFP, should be accompanied by a statement of the costs of the professional services to be provided by the PSRO in accordance with OMB Circular A-87, Attachment B, Section C-7. The regional office will advise the State of its decision on the plan amendment within 30 days of receipt of it. The maximum duration of the contract is suggested as 12 months, with a provision that the contract is terminated if HCFA terminates funding for the PSRO's review of Medicare utilization.

2352. PLAN AMENDMENT

The plan amendment must contain a provision which indicates that the contract with the PSRO satisfies the requirements that:

l. The provisions of paragraphs (a),(b),(c),(g),(h),(i),(m), and (n) of 42 CFR Section 431.503 are met;

2. A monitoring and evaluation plan is in effect by which the State will assure satisfactory performance by the PSRO;

3. The services and providers subject to PSRO review are identified; and

4. The review activities performed by the PSRO are not inconsistent with those activities performed for the review of Title XVIII services, including a description of whether and to what extent PSRO determinations will be considered conclusive for payment purposes.

The plan amendment and any subsequent modification should be cross-referenced to the "Utilization Control" State plan preprint page. If a State is required to modify its plan amendment concerning the contract, it must resubmit the plan amendment at least 30 days before the effective date of the contract.

Should the Administrator reject the State plan amendment for PSRO contracted review, FFP would not be available for expenses the State may have incurred under the contract. The State would become liable for the cost of PSRO contracted review until the beginning of the quarter in which an approvable amendment is submitted. Therefore, it is recommended that the State and PSRO maintain contact with the HCFA regional office during the contract negotiation process. This should prevent the incorporation or exclusion of contract elements of such a critical nature that eventual State plan amendment approval would be jeopardized.

2353. FUNCTIONS UNDER THE STATE-PSRO CONTRACT

States have broad latitude as to the type of medical necessity and/or utilization review PSROs will perform. At the minimum, the contracting PSRO should include a utilization review function such as prior authorization, concurrent review, or post-service review. The State-PSRO contract may specify review responsibilities by type of review, by type of service (ambulatory, inpatient, ancillary, physician etc), or by type of provider (acute hospital, specialty hospital, SNF, or ICF). For the services or providers to be reviewed under the contract, the associated utilization review or medical review requirements will be deemed met, as specified in the Medicaid plan amendment.

2353.1 State Agency Authority.--Since the State agency has the option of contracting, PSRO review does not have to be binding on the State agency. It is the State agency which retains full legal responsibility for all Medicaid review decisions. The only exception is for beneficiaries who are dually entitled to Medicaid and Medicare, where the PSRO determination of medical necessity for Medicare will be binding upon the State up to the limit of Medicare coverage, when the State has contracted with a Federally funded PSRO.

The State agency does not have to accept delegated review in facilities where it exists for Title XVIII. It may require the PSRO itself to perform the Medicaid review it wishes carried out.

It should be understood that no coverage or eligibility provisions may be contracted to the PSRO for determination. Only the appropriate State agency may lawfully decide coverage or eligibility issues.

2354. STATE AGENCY JURISDICTION FOR HEARING AND APPEALS

The amended PSRO-State relations provided in PL 97-35 remove Medicaid decisions under a State-PSRO contract from the hearings provisions of Sec. 1159 of the Act. Immediately following the termination of Federally funded PSRO review the fair hearings provisions of the existing regulation, 42 CFR Part 430 Subpart E, Fair Hearings for Applicants and Recipients will again apply to all determinations regarding Medicaid services. The State agency is the legal entity responsible under the statute. The State may negotiate a PSRO which is under contract into the evidentiary hearings process. Payment for services which the State agency has disapproved, but for which a hearing is pending, must be continued as specified under 42 CFR 431.230 Maintaining Services. Under the Medicaid fair hearings regulations, only the applicant or recipient is a party to the proceedings. No provision exists in the existing Medicaid regulations for a physician or provider to appeal a decision which is adverse to the applicant or recipient.

2355. RESPONSIBILITIES OF A STATE THAT DOES NOT CONTRACT WITH A PSRO

The following are State responsibilities which must be assumed by the Medicaid agency if it does not choose to contract for review by a PSRO, including those instances in which Federal funding for Medicare review by a PSRO has been terminated.

1. Review Activities - Medical review, utilization review, independent professional review - Sections 1902(a)(26), 1902(a)(30), 1902(a)(31), 1903(g)(1) and 1903(i)(4) of the Social Security Act,

2. Certification and Recertification of Patient Care - Section 1903(g)(1)(A) of the Act,

3. Plan of Care - Section 1903(g)(1)(B),

4. Medical Necessity, Quality and Appropriateness of Level of Care Determinations - Section 1903(g) and 1903(i)(4) of the Act,

5. Coordination with State survey agencies under Section 1902(a)(33) of the Act.

6. Submit quarterly showings beginning with the first full quarter of State review responsibility and every quarter thereafter.

A State is responsible for the requirements listed above as soon as Federal funding to a PSRO for Medicaid review is terminated. HCFA will assume that all recertification and annual review requirements were met as of the last day of PSRO responsibility so that the State need not recertify patients for 60 days after defunding and need not perform annual reviews until the same calendar quarter in which defunding occurred, 1 year later. States are still required to make a satisfactory showing that the UC requirements have been met in those facilities previously within the jurisdiction of a PSRO in each quarter following PSRO defunding. States failing to make a satisfactory showing of an effective utilization control program will become penalty liable pursuant to 42 C.F.R. 456.657.

2355.1 Contracts not Matched at 75 Percent FFP.--A PSRO Statewide Council and a PSRO defunded for Medicare review are not considered qualified organizations for purposes of contracting to receive 75 percent FFP. If a PSRO has already been defunded for Medicare review or is otherwise terminated by HCFA, any contractual arrangements between it and a State are not considered contracts under Section 2113. Consequently, such contracts do not qualify for the special 75 percent FFP under Section 2113, UR requirements are not automatically deemed met, and OMB Circular A-102 procurement requirements remain applicable on a case-by-case basis. States which contract with review organizations not designated as PSROs are eligible for 50 percent FFP.

Where a PSRO has been defunded for Medicare review, that organization should cease using a separate data system from the Medicaid Management Information System (MMIS) if the State has a certified MMIS. States without certified MMIS may permit a defunded PSRO to use the PSRO Management Information Systems (PMIS). PSRO's not defunded for Medicare review may use either PMIS or MMIS.

2356. TRANSITION ISSUES

P.L. 97-35 repeals Section 1171 of the Social Security Act covering Federal-State relations as to PSROs, Memoranda of Understanding (MOUs) and State monitoring plans. Existing State MOUs with active PSROs remain in effect until HCFA terminates its direct funding of Medicaid review for each of the PSROs on an area by area basis.

2450. CONFLICT OF INTEREST PROVISIONS--GENERAL

Under section l902(a)(4)(C) of the Social Security Act, State plans must provide that the following individuals are prohibited from committing any act, in relation to any activity under the plan, that is prohibited for Federal employees under sections 207 and 208 of Title l8 of the U.S. Code:

l. Each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan,

2. Each individual who formerly was such an officer or employee, and

3. Each partner of such an officer or employee.

245l. DEFINITIONS

A. State or local officer or employee - any individual who is retained, designated, appointed or employed by the State or local government to perform, with or without compensation, on a full-time, part-time or intermittent basis, regular or temporary duties that relate to any activities under the State plan for medical assistance approved under title XIX of the Social Security Act.

B. Responsible for the expenditure - any State or local officer or employee who has the legal authority to direct, decide, approve, disapprove, recommend, advise, investigate, or perform other similar activities with respect to expenditures of funds under the State plan. This would encompass not only an official who has the authority to determine the amount of money to be spent, how it is to be spent, or to whom it is to be paid, but also any officer or employee who has the authority to adjudicate any disputes over entitlement to expenditures, or compliance with requirements imposed upon the use of funds.

C. Substantial amounts of funds - amount of money which, if stolen, would constitute a felony under State law. In those States that do not distinguish between felonious and misdemeanor larceny on the value of property stolen, $l00 may be used as the definition of "substantial amount."

D. Financial interest - any interest of monetary value which may be directly and predictably affected by the official action of the State or local officer or employee. There is no minimum amount of value or control that constitutes a financial interest.

E. Official responsibility - the direct administrative or operating authority, whether intermediate or final, and either exercisable alone or with others, and either personally or through subordinates, to approve, disapprove, or otherwise direct government action.

2452. PROHIBITED ACTIVITIES

Sections 207 and 208 of Title l8, U.S. Code, are criminal statutes aimed at preventing the use of public office to further private interests and to prevent private interests from influencing public officials in discharging their duties. While Section l902(a)(4)(c) is not a criminal law, it does aim to safeguard Medicaid funds from unethical practices as defined by Federal law.

The affected State or local employee is prohibited from committing any act, in relation to any activity under the plan, which would be a crime under the statute if committed by present or former employees of the Federal Government. Details are provided in the following reprint of Sections 207 and 208 of the statute:

§207 Disqualification of former officers and employees; disqualification of partners of current officers and employees.

(a) Whoever, having been an officer or employee of the executive branch of the United States Government, of any independent agency of the United States, or of the District of Columbia, including a special Government employee, after his employment has ceased, knowingly acts as agent or attorney for, or otherwise represents, any other person (except the United States), in any formal or informal appearance before, or, with the intent to influence, makes any oral or written communication on behalf of any other person (except the United States) to-

(l) any department, agency, court, court-martial, or any civil, military, or naval commission of the United States or the District of Columbia, or any officer or employee thereof, and

(2) in connection with any judicial or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter involving a specific party or parties in which the United States or the District of Columbia is a party or has a direct and substantial interest, and

(3) in which he participated personally and substantially as an officer or employee through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise, while so employed; or

(b) Whoever, (i) having been so employed, within two years after his employment has ceased, knowingly acts as agent or attorney for, or otherwise represents, any other person (except the United States), in any formal or informal appearance before, or, with the intent to influence, makes any oral or written communication on behalf of any other person (except the United States) to, or (ii) having been so employed and as specified in

subsection (d) of this section, within two years after his employment has ceased, knowingly represents or aids, counsels, advises, consults, or assists in representing any other person (except the United States) by personal presence at any formal or informal appearance before-

(l) any department, agency, court, court-martial, or any civil, military, or naval commission of the United States or the District of Columbia, or any officer or employee thereof, and

(2) in connection with any judicial or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter involving a specific party or parties in which the United States or the District of Columbia is a party or has a direct and substantial interest, and

(3) as to (i) which was actually pending under his official responsibility as an officer or employee within a period of one year prior to the termination of such responsibility, or, as to (ii) in which he participated personally and substantially as an officer or employee; or

(c) Whoever, other than a special Government employee who serves for less than sixty days in a given calendar year, having been so employed as specified in subsection (d) of this section, within one year after such employment has ceased, knowingly acts as agent or attorney for, or otherwise represents, anyone other than the United States in any formal or informal appearance before, or, with the intent to influence, makes any oral or written communication on behalf of anyone other than the United States, to-

(l) the department or agency in which he served as an officer or employee, or any officer or employee thereof, and

(2) in connection with any judicial, rulemaking, or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter, and

(3) which is pending before such department or agency or in which such department or agency has a direct and substantial interest-

shall be fined not more than $l0,000 or imprisoned for not more than two years, or both.

(d)(l) Subsection (c) of this section shall apply to a person employed-

(A) at a rate of pay specified in or fixed according to subchapter II of chapter 53 of title 5, United States Code, or a comparable or greater rate of pay under other authority;

(B) on active duty as a commissioned officer of a uniformed service assigned to pay grade of 0-9 or above as described in section 20l of title 37, United States Code; or

(C) in a position which involves significant decision-making or supervisory responsibility, as designated under this subparagraph by the Director of the Office of Government Ethics, in consultation with the department or agency concerned. Only positions which are not covered by subparagraphs (A) and (B) above, and for which the basic rate of pay is equal to or greater than the basic rate of pay for GS-l7 of the General Schedule prescribed by section 5332 of title 5, United States Code, or positions which are established within the Senior Executive Service pursuant to the Civil Service Reform Act of l978, or positions of active duty commissioned officers of the uniformed services assigned to pay 0-7 or 0-8, as described in section 20l of title 37, United States Code, may be designated. As to persons in positions designated under this subparagraph, the Director may limit the restrictions of subsection (c) to permit a former officer or employee, who served in a separate agency or bureau within a department or agency, to make appearances before or communications to persons in an unrelated agency or bureau, within the same department or agency, having separate and distinct subject matter jurisdiction, upon a determination by the Director that there exists no potential for use of undue influence or unfair advantage based on past government service. On an annual basis, the Director of the Office of Government Ethics shall review the designations and determinations made under this subparagraph and, in consultation with the department or agency concerned, make such additions and deletions as are necessary. Departments and agencies shall cooperate to the fullest extent with the Director of the Office of Government Ethics in the exercise of his responsibility under this paragraph.

(2) The prohibition of subsection (c) shall not apply to appearances, communications, or representation by a former officer or employee who is-

(A) an elected official of a State or local government, or

(B) whose principal occupation or employment is with (i) an agency or instrumentality of a State or local government, (ii) an accredited, degree-granting institution of higher education, as defined in section l20l(a) of the Higher Education Act of l965, or (iii) a hospital or medical research organization, exempted and defined under section 50l(c)(3) of the Internal Revenue Code of l954, and the appearance, communication, or representation is on behalf of such government, institution, hospital, or organization.

(e) For the purposes of subsection (c), whenever the Director of the Office of Government Ethics determines that a separate statutory agency or bureau within a department or agency exercises functions which are distinct and separate from the remaining functions of the department or agency, the Director shall by rule designate such agency or bureau as a separate department or agency; except that such designation shall not apply to former heads of designated bureaus or agencies, or former officers and employees of the department or agency whose official responsibilities included supervision of said agency or bureau.

(f) The prohibitions of subsections (a), (b), and (c) shall not apply with respect to the making of communications solely for the purpose of furnishing scientific or technological information under procedures acceptable to the department or agency concerned, or if the head of the department or agency concerned with the particular matter, in consultation with the Director of the Office of Government Ethics, makes a certification, published in the Federal Register, that the former officer or employee has outstanding qualifications in a scientific, technological, or other technical discipline, and is acting with respect to a particular matter which requires such qualifications, and that the national interest would be served by the participation of the former officer or employee.

(g) Whoever, being a partner of an officer or employee of the executive branch of the United States Government, of any independent agency of the United States, or of the District of Columbia, including a special Government employee, acts as agent or attorney for anyone other than the United States before any department, agency, court, court-martial, or any civil, military, or naval commission of the United States or the District of Columbia, or any officer or employee thereof, in connection with any judicial or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, investigation, charge, accusation, arrest, or other particular matter in which the United States or the District of Columbia is a party or has a direct and substantial interest and in which such officer or employee or special Government employee participates or has participated personally and substantially as an officer or employee through decision, approval, disapproval, recommendation, the rendering of advice, investigation, or otherwise, or which is the subject of his official responsibility, shall be fined not more than $5,000, or imprisoned for not more than one year, or both.

(h) Nothing in this section shall prevent a former officer or employee from giving testimony under oath, or from making statements required to be made under penalty of perjury.

(i) The prohibition contained in subsection (c) shall not apply to appearances or communications by a former officer or employee concerning matters of a personal and individual nature, such as personal income taxes or pension benefits; nor shall the prohibition of that subsection prevent a former officer or employee from making or providing a statement, which is based on the former officer's or employee's own special knowledge in the particular area that is the subject of the statement, provided that no compensation is thereby received, other than that regularly provided for by law or regulation for witnesses.

(j) If the head of the department or agency in which the former officer or employee served finds, after notice and opportunity for a hearing, that such former officer or employee violated subsection (a), (b), or (c) of this section, such department or agency head may prohibit that person from making, on behalf of any other person (except the United States), any informal or formal appearance before, or, with the intent to influence, any oral or written communication to, such department or agency on a pending matter of business for a period not to exceed five years, or may take other appropriate

disciplinary action. Such disciplinary action shall be subject to review in an appropriate United States district court. No later than six months after the effective date of this Act, departments and agencies shall, in consultation with the Director of the Office of Government Ethics, establish procedures to carry out this subsection. (As amended Pub. L. 95-52l, Title V, &50l(a), Oct. 26, l978, 92 Stat. l864; Pub. L. 96-28, June 22, l979, 93 Stat. 76.)

§208 Acts Affecting a Personal Financial Interest

(a) Except as permitted by subsection (b) hereof, whoever, being an officer or employee of the executive branch of the United States Government, of any independent agency of the United States, a Federal Reserve bank director, officer, or employee, or of the District of Columbia, including a special Government employee, participates personally and substantially as a Government officer or employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation, or otherwise, in a judicial or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, charge, accusation, arrest, or other particular matter in which, to his knowledge, he, his spouse, minor child, partner, organization in which he is serving as officer, director, trustee, partner or employee, or any person or organization with whom he is negotiating or has any arrangement concerning prospective employment, has a financial interest-

Shall be fined not more than $l0,000 or imprisoned not more than two years, or both.

(b) Subsection (a) hereof shall not apply (l) if the officer or employee first advises the Government official responsible for appointment to his position of the nature and circumstances of the judicial or other proceeding, application, request for a ruling or other determination, contract, claim, controversy, charge, accusation, arrest, or other particular matter and makes full disclosure of the financial interest and receives in advance a written determination made by such official that the interest is not so substantial as to be deemed likely to affect the integrity of the services which the Government may expect from such officer or employee, or (2) if, by general rule or regulation published in the Federal Register, the financial interest has been exempted from the requirements of clause (1) hereof as being too remote or too inconsequential to affect the integrity of Government officers' or employees' services. In the case of class A and B directors of Federal Reserve banks, the Board of Governors of the Federal Reserve System shall be the Government official responsible for appointment. (As amended Pub. L. 95-l88, Title II, §205, November l6, l977, 9l Stat. l388.)

NOTE: Additional interpretations, standards, and definitions which may apply with respect to the above-described conflict of interest provisions can be found in 5 CFR Part 737 and 45 CFR Part 73.

2490. CLAIMING FEDERAL FINANCIAL PARTICIPATION (FFP) FOR ADVANCE PAYMENTS MADE TO PROVIDERS OF MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT--FEDERAL FINANCIAL PARTICIPATION

A. LEGAL BACKGROUND AND AUTHORITY

42 CFR 435, Eligibility in the States and District of Columbia, Subpart K - Federal Financial Participation

B. STATEMENT OF POLICY

There are no Federal regulations that would prohibit a State from making payments in advance to title XIX providers for services not yet rendered. However, the State may claim FFP only for Medicaid services which were actually rendered title XIX recipients during a period eligibility, and which were appropriately billed to the State agency and supported by adequate documentation. The State, however, may claim FFP in Periodic Interim Payments (PIP) made for medical services which have already been provided but for which individual billings have not yet been processed completely.

Medicaid regulations at 42 CFR 440, subpart A, specify that FFP is available in expenditures under the State plan for the medical care and services defined in the subpart. Since the regulations make it clear that the services must first be provided or furnished, FFP claimed for advances paid by the State is unallowable, and will be considered an overpayment subject to recovery by the Secretary pursuant to Section 1903 (d)(2) of the act.

2490.1 Nonexpendable Personal Property

A. LEGAL BACKGROUND AND AUTHORITY

Section 1102 of the Social Security Act 42 CFR 433.35

B. DEFINITIONS

1. Acquisition cost - The net amount expended by the State agency for the property (excluding interest) plus, in the case of property acquired with a trade-in, the book value of the property traded in.

2. Book value - The acquisition cost of the property less the amount depreciated through the date of trade-in. (If the State claimed FFP in the acquisition cost when it acquired the property, the book value is zero.)

3. Depreciation expense - That portion of the acquisition cost assignable to a particular time period of the estimated useful service life of the property.

4. Nonexpendable personal property - Tangible property of any kind, except real property, that has a useful life of more than one year and an acquisition cost of $300 or more per unit.

C. AVAILABILITY OF FFP

1. FFP may be claimed in full for nonexpendable personal property costing less than $5000 if the property is charged to a direct cost center and the State agency has title to the property.

2. FFP may be claimed only for the depreciation expense or an annual use allowance of 6 2/3 percent of acquisition cost during the period the property is used in the Medicaid program, for nonexpendable personal property costing more than $5,000 and charged to a direct cost center.

3. FFP may be claimed only for the depreciation expense or an annual use allowance of 6 2/3 percent of acquisition cost during the period the property is used in the Medicaid program, for nonexpendable personal property charged to indirect cost centers or pools under the cost allocation plan.

4. A combination of the depreciation/use allowance methods may not be used in connection with any specific asset or any class of assets. The method chosen must be consistently applied for any specific asset or class of assets.

5. When an item of nonexpendable personal property has been fully depreciated, no further charges may be made to the Medicaid program.

D. COST CALCULATION EXAMPLES

Example 1 - The State agency purchased a word processing machine in 1977 for $4,900. Since the acquisition cost is less than $5,000, the State agency expenses the word processing machine and the State agency claims and receives FFP.

In 1979 the State agency purchases a word processing machine with a purchase price of $5,500. The State agency also trades in the 1977 word processing machine and receives $2,000 trade-in value. The acquisition cost of the 1979 word processing machine is $3,500 ($5,500 -$2,000). There is no book value for the 1977 word processing machine as it was expensed and FFP claimed in full at the time of purchase. Since the acquisition cost of the 1979 word processing machine is $3,500 the word processing machine may be expensed.

Example 2 - The State agency purchases a word processing machine in 1977 for $5,400. Since the acquisition cost is in excess of $5,000 the word processing machine is capitalized. The State agency chooses to depreciate the word proceesing machine using straight-line depreciation. The word processing machine has a useful service life of 9 years. Each year the State agency may claim FFP for the $600 ($5,400 divided by 9) depreciation expense.

In 1979 the State agency purchases a word processing machine with a purchase price of $5,700. The State agency also trades in the 1977 word processing machine and receives $3,000 trade-in value. The acquisition cost of the 1979 word processing machine is $6,900 ($5,700 - $3,000 + $4,200). The book value of the 1977 word processing machine is $4,200, $5,400 - ($600 x 2). Since the acquisition cost of the 1979 word processing machine is $6,900 the word processing machine must be capitalized.

E. DISTRIBUTION OF COSTS

1. Items of nonexpendable personal property may be acquired by the State agency and be used exclusively for the benefit of the Medicaid program or they may be acquired and be used for the benefit of several Federal programs, including Medicaid.

2. The full acquisition cost or the depreciation expense or use allowance (see section 2490.1C.1. and 2. above) for those items of nonexpendable personal property utilized solely in the

Medicaid program, may be directly charged to Medicaid and reimbursed at the 50 percent FFP rate for administrative costs.

Example 1 - The State agency purchases a programmable calculator that will be used to determine Medicaid eligibility for varying income levels. The acquisition cost of the calculator is $4,000. Since this calculator is to be used exclusively for the benefit of the Medicaid program and the acquisition cost is $4,000 (see section 2490.1C.1. above), the State agency can directly charge the total $4,000 to Medicaid. At the 50 percent FFP rate the State agency would be reimbursed $2,000.

Example 2 - The State agency purchases the same calculator as in the example above, however, the acquisition cost is $6,000. The State agency elects (see section 2490.1C.2. above) to depreciate the calculator, using the straight-line method of depreciation, over a useful life of 5 years. For each of the 5 years that the calculator is used exclusively for the benefit of the Medicaid program the State agency may directly charge the $1,200 ($6,000 divided by 5) depreciation expense to Medicaid. At the 50 percent FFP rate the State agency would be reimbursed §600.

3. The depreciation expense or use allowance (see section 2490.1C.3 above) for those items of nonexpendable personal property which only indirectly benefit the Medicaid program, must be charged to Medicaid through the State agency cost allocating plan. The State agency will be reimbursed at the 50 percent FFP rate for that portion of the depreciation expense or use allowance allocable to Medicaid.

   Example - The State agency purchases an electric typewriter that will be used by the State agency Personnel Department. This department is engaged in duties that benefit all programs, including Medicaid, administered by the State agency. The acquisition cost of the typewriter is $500. The State agency elects (see section 2490.1C.3. above) to depreciate the typewriter, using the straight-line method of depreciation, over a useful life of 5 years. For each of the years, up to the maximum 5 years, that the typewriter is in use, the State agency may include the $100 ($500 divided by 5) depreciation expense in its indirect cost pool or center. This depreciation expense would then be allocated to the Medicaid program in accordance with the cost allocation plan. In this instance, if the Medicaid program was allocated $40 of the $100 depreciation expense the State agency would be reimbursed $20 at the 50 percent FFP rate.

Refer to OASC-10, A Guide for State and Local Government Agencies - Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government, for the specific development and use of cost allocation plans.

F. Standards for Nonexpendable Personal Property.--Nonexpendable personal property which you acquire wholly or in part with HHS funds, is subject to the property management and accountability and procurement standards of 45 CFR Part 74. Nonexpendable personal property for which you claim FFP in depreciation or a use allowance is not subject to the requirements of 45 CFR Part 74. You may use your own property management standards and procurement regulations which reflect applicable State laws and rules.

2493. CLAIMING FFP FOR PROVIDER PAYMENTS FOR STATE TAXES

A. Legal Background and Authority.--The availability of FFP in Medicaid reimbursement to providers, including hospitals and nursing homes for various fees and taxes, imposed by either State or local government agencies, is governed by the provisions at §1903(a) of the Act. Section 1903(a) specifies that FFP is available in expenditures made by a State for medical assistance under the State's reimbursement plan.

In determining the total amount legitimately expended under the State plan, you may not include payments made to a provider for those taxes which are either not imposed on all businesses or other entities in the State or for which the Medicaid recipient would pay the tax to the provider.

B. Availability of FFP.--

1. Taxes of General Applicability.--Where a tax is not restricted to medical providers of care or services and is applied to all types of businesses (e.g., taxes on real property, general excise taxes, or taxes for workers' compensation funds) payment by the State to providers which recognized such a tax would be an allowable expenditure for FFP purposes.

However, where the tax has been specifically imposed only on medical care and/or services, (e.g., taxes on health care providers' net revenues, user fees assessed on a per bed, or per admission basis, or licensing fees) you will not be considered as having incurred an expense and, therefore, FFP will not be available in expenditures related to that type of tax.

2. Taxes Paid by Providers.--When the tax is paid by the provider, the tax is allowable for FFP purposes (subject to B.1). However, where the tax would be paid for by the Medicaid recipient, e.g., sales taxes paid by the patient, FFP will not be available.